reiter, hill johnson + nevin

How did you hear about us?
(Please Circle)

Google Facebook Yelp Referral Other: ______________

Patient ID: ____________

Patient Information

First Name:	M.I.:	Last Name:	
Email address:		Date of Birth: ___/____/_____ Age:	
Address:	Apt. #	Marital Status: ☐S ☐M ☐D ☐W	
City:			
State:	Zip:		
Phone(h):	Phone(c):	Phone(w):	Ext:
Employer:		Occupation:	
Work Address:		SSN:	

Race	Ethnicity	Preferred Language
☐ American Indian/ Alaska ☐ Native Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Decline to answer	☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Decline to answer	☐English ☐Spanish ☐Other (please specify):______________________________ **Emergency Contact** Name: Phone Number:

Pharmacy Information	Preferred Method of Contact
Preferred Pharmacy Name: Pharmacy Zip: Pharmacy Phone:	Phone ☐Home ☐Cell ☐Work
Referring Physician:	Referring Physician Phone Number:

Primary Insurance

Insurance Company Name:	Policy Number:	Group Number:
Insurance Company Address:		Date Effective:
Subscriber's Name:	Relationship to Patient (If Self, leave this section blank) :	
Subscriber's Address:	Subscriber's SSN:	
Subscriber's DOB:	Sex: ☐ M ☐ F	

Secondary Insurance

Insurance Company Name:	Policy Number:	Group Number:
Insurance Company Address:		Date Effective:
Subscriber's Name:	Relationship to Patient (If Self, leave this section blank) :	
Subscriber's Address:	Subscriber's SSN:	
Subscriber's DOB:	Sex: ☐ M ☐ F	

Authorization Acknowledgement

I hereby confirm that all the information provided by me is accurate.	Signature (Patient or Parent if minor)	DATE